TRACKING FORM
5 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Dresses without help, knows own address, can count on fingers, recognizes most letters of alphabet, prints some letters.
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
Urinalysis (Required)		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Good parenting practices
[ ] Nutrition
[ ] Street safety
[ ] Should know full name, address, and phone number
[ ] Dental care
[ ] School readiness
[ ] Discipline
[ ] Household chores

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No